Geriatric Dental Medical History Form

Patient Information

Full Name

Date of Birth

Gender

Phone Number

Address

Emergency Contact Name & Phone

Medical History

- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Stroke
- [ ] Diabetes
- [ ] Arthritis
- [ ] Osteoporosis
- [ ] Cancer
- [ ] Kidney Disease
- [ ] Lung Disease
- [ ] Bleeding Disorders
- [ ] Dementia/Memory Issues
- [ ] Psychiatric Illness
- [ ] Other

Please list other conditions or more information

List any major surgeries or hospitalizations

Medications

List all current medications (include over-the-counter & supplements)

Allergies (including medications/dental materials/latex)

Dental History

- [ ] Dentures/Partials
- [ ] Bleeding Gums
- [ ] Dry Mouth
- [ ] Tooth Pain
- [ ] Difficulty Chewing/Swallowing
- [ ] Jaw Problems
- [ ] Oral Cancer
- [ ] Other

Please provide details on any dental concerns

Consent & Signature

Patient/Responsible Party Signature

Date